Vaccine Administration Record

ALPS Pharmacy
2650 W Kearney St
Springfield, MO 65803-2037
Phone: (417) 865-1547 Fax: (417) 862-2571

Name: _____ **Male:** __ **Female:** __ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Allergies:** _____ **Race:** _____

Primary Care Doctor: _____ **Office Phone Number:** _____

Address: _____ **Office Fax Number:** _____

SSN: _____

Bin: **021684** ***Group:*** ***Insurance Name:*** **anthem**

Member ID **Please Provide Pharmacy with current insurance card, if possible.**

Screening Questions

1. Are you sick today? (Pharmacy staff-list current temperature: _____) Do you have a pending COVID test?	Yes	No
2. Do you have allergies to medications, food, eggs, yeast, a vaccine component, or latex?	Yes	No
3. Have you ever had a serious reaction after receiving a vaccination?	Yes	No
4. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohns disease, psoriasis or had radiation treatments?	Yes	No
5. In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, and/or other steroids, or anticancer drugs, or have you had radiation treatments?	Yes	No
6. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	Yes	No
7. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No N/A
8. Have you received any vaccinations or a TB skin test in the past 4 weeks?	Yes	No
9. Have you received convalescent plasma or monoclonal antibody treatments for the treatment of COVID?	Yes	No

Consent:

- I have received and read the Emergency Use Authorization Fact Sheet and understand this medication is only available under emergency authorization and further monitoring is being done. I accept that there may be some unknown risks.
- Your healthcare provider will keep this form and any information collected in a confidential manner. If we are billing your insurance you authorize the release of any medical or other information necessary to process the claim and request payment to Alps
- I verify the above information as correct and accurate for the use of my healthcare provider to make clinical assessment with. There are risks associated with all medicines. I have had a chance to ask questions and had them answered.
- I will immediately report side effects or concerns to the pharmacist and the physician. The pharmacist recommends waiting for a minimum of 15 to 30 minutes after administration of any medication to be monitored for adverse events.
- I consent for my immunization history to be reported to the government immunization information system unless you opt out by not selecting this box unless otherwise required by state or federal mandate.

Name (print): _____ **If guardian check this box:** ☐

Signature: _____ **Date** _____

Second Dose Scheduled For: _____ Verified Pioneer MTM Created: _____ Last dose received: _____

Administration (Pharmacist Use Only)

Vaccine:	Manufacturer:	Admin Directions:	Dose:	Lot:	Exp:	Dose:	Inj Site:
Covid-19 2023-2024 Formulation	Moderna Spikevax 80777-0102-93	Inject 0.5ml IM for one dose	1st			0.5ml	LD RD
Covid-19 Original Formulation	Novavax 80631-0100-10	Inject 0.5ml IM for 2 doses, 3-8 weeks apart	1st 2nd 1B			0.5ml	LD RD

Rx _____
Substitution Permitted

Signature of immunizer and Date:

_____

RPh Supervisor (if applicable): _____ Faxed PCP if applicable (Date/Time): _____ Initials: _____